Arizona Department of Health Services

Chronic Disease Disparities In Arizona: From Awareness To Action

April 13 – 15, 2005

Three Discussion Areas:

I. **Collaboration and Community Mobilization**

II. **Outreach, Public Education and Prevention**

III. **Public Policy, Access and Quality of Care**

Collaboration and Community Mobilization

Issues

- Coordination of “Grass Roots Efforts”
- Community dialogue (listen)
- Identifying gaps and maximizes resources
- Engage the public
- Develop Local Capacity

Recommendations:

1. Develop sustainable capacity for collaboration community mobilization:

- ✓ Provide training/ institute a regular program of professional development around health disparities;
- ✓ Mentoring providers – peer to peer;
- ✓ Developing regional experts in specific health disparities arenas.

Recommendations:

2. Listening to communities and engaging them in dialogue:

- ✓ Visibility in local communities of influential leaders (responsible for policy making/decision making);
- ✓ Standard business practice to listen before acting;
- ✓ Ensure communities are defined as not just providers;
- ✓ Government needs to collaborate on local town halls (Health related agencies).

Recommendations:

3. Ensuring accountability to maximize our efforts:

- ✓ Internal evaluation of effectiveness for all entities (government, private sector, etc.);
- ✓ Reward innovation and creativity (both internally and externally);
- ✓ Becoming more familiar with research based practices – what really works in communities.

Burning Questions:

- ✓What are your plans for collaborating with other agencies in order to listen to and develop plans with communities?

- ✓Are you willing to share conference information and feedback with sister agencies (i.e.:Department of Education)?

Outreach, Public Education and Prevention

Issues:

- Too much duplication of services due to poor communication amongst service providers;
- Need for community input into the type of outreach, prevention and education needed for various types of communities;
- Lack of funding for outreach and training.

Recommendations:

1. Coordination and collaboration in developing outreach, education, prevention/intervention and training:

- ✓ Use of focus groups;
- ✓ Utilization of community action groups already in place;
- ✓ Creation of community action groups where needed;
- ✓ Incorporate the use of evidence-based practices.

Recommendations:

2. Customize training for various communities:

- ✓ Incorporate cultural perspectives;
- ✓ Use of social marketing strategies;
- ✓ Understand resource inequities exists;
- ✓ Metro versus rural needs;
- ✓ Level of knowledge/expertise of individuals that will be trained.

Recommendations:

3. Increase long-term sustainable funding for statewide outreach, prevention and education:

- ✓ State agencies to hire additional outreach staff;
- ✓ Provide grant opportunities to community-based organizations to hire outreach staff.

Burning Questions:

None Noted

Public Policy, Access and Quality of Care

Issues:

- 1.Education for caregivers re: linguistics and cultural competency.
- 2.Increase the number of physicians who take AHCCCS; increase the type of certified & licensed health care providers that take AHCCCS (e.g. nurse practitioners, RD's, etc.); increase those recognized by AHCCCS.
- 3.Increase access, regardless of payor, for dental & behavioral health services for under and un insured.

Issues:

- 4.Increase access to “well woman” services, e.g. cancer screening, treatment, birth control for all women.
- 5.Include representatives from population being served in decision making entities; include consumers in Advisory groups.
- 6.Tribal concerns: (a) Support Self-determination and sovereignty; (b) Disseminate best practices for tribes in systematic way; (c)Breakout AI data at community level.

Recommendations:

1. A. Require all providers to have at least 4 hours of CME/CEU for every certification cycle. (cultural competency)

1. B. Require 10 hours training on cultural competency and language for all health care professionals.

Recommendations:

2.A. Increase type and number of licensed or certified health care providers;

2.B. Increase those recognized by AHCCCS; recognize all licensed providers – i.e. nurse practitioners, RD's, etc.

Recommendations:

2.C. Increase School Based health models such as University, College, School Based Clinics; take health care to patients/consumers.

2.D. Have AHCCCS approve collaborative, multiple practitioner visits on same day. This would increase compliance, decrease cost to patient, decrease cost/labor to clinic, and increase coordination and continuity of care.

Recommendations:

3.A. Include Behavioral Health Specialist and Behavioral Health Specialty Services as part of a primary care team at Community Health Centers and Doctor Offices.

3.B. Provide support to School Based preventive dental services for children.

Recommendations:

4. Have policies (state and federal) for free outreach programs & health care programs for GYN.
5. Community group inclusion mechanism(s):

   a) Use a Governor Summit model (like that used in Native American Summit) where the Governor designates agency heads to follow-up on recommendations; b) use existing community advisory boards; c) elevate issues from the community and access safe havens such as Schools, Head Start, Senior Centers to reach consumers; d) have three plans that address Leadership, Outreach, and Education.

Recommendations:

6. Tribal Issues-

Support Self-determination and sovereignty (recognize urban needs as well):

6.a. Develop a network from DES, ADHS, AHCCCS to advocate for tribes;

- E.g. diabetes funding;

6.c. Establish federally funded facilities on reservation;

6.d. Advocate for change in service delivery;

the reservation;

Recommendations:

6.e. Help reservation build capacity by providing technical assistance to build and operate Health and Behavioral Health on the reservation;

6. f. Ensure cultural sensitivity for mental health; RBHA's are not working now. Disseminate Best Practices for Tribes in systematic way.

6.g. Facilitate procedure for certification of lay health workers.

6.h. Develop prevention program model.

Recommendations:

6.i. Address secondary conditions related to disability; i.e. a Diabetic amputation may have mental health issues after procedure. This needs to be addressed. Breakout AI data at community level.

6.j. Formulate procedures for dissemination of information regarding morbidity/mortality data; the tribes are not getting the information.

Burning Questions:

Are you willing to reframe communication to engage the public's response to health disparity?

Are you willing to use correct and appropriate data on health disparities?